



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DBA INJURY 1 OF DALLAS
SUITE 1000
9330 LBJ FREEWAY
DALLAS TX 75243

Respondent Name

TEXTRON INC

Carrier's Austin Representative

Box Number 47

MFDR Tracking Number

M4-13-0009-01

MFDR Date Received

September 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was referred for an Initial Behavioral Medicine Consultation which then recommended Individual sessions. The services were provided and the claims were denied per EOB based on the findings of a review organization. The services provided were preauthorized (#4353061) therefore it is deemed medically necessary. Also denied based on extent of injury."

Amount in Dispute: \$3,504.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 request was placed in the insurance carrier's representative box 47 assigned to Burns Anderson Jury Brenner & Donovan on September 11, 2012. The DWC060 request was stamped received by Debrah Derrickson on September 12, 2012. The MDR section will therefore issue a decision based on the documentation contained in the dispute at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2011 through May 23, 2012	90801, 90806, 96151 and 96101	\$3,504.53	\$750.74

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 080-001 – Review of this bill has resulted in an adjusted reimbursement for the entire bill of \$0.00.
- 216 – Based on the findings of a review organization
- 94 – Processed in excess of charges. \$0.00
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
- 075-001 – The allowance for this code has been included in the allowed amount in explanation code 080-001.

Issues

1. Are the disputed services rendered on October 25, 2011 through April 9, 2012 eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
2. Did the requestor obtain preauthorization for date of service May 23, 2012?
3. Did the requestor bill in conflict with the NCCI edits?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

28 Texas Administrative Code §133.307(e) (3) (G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution.

Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution for dates of service October 25, 2011 through April 9, 2012.

The requestor has failed to support that dates of service October 25, 2011 through April 9, 2012 are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

2. 28 Texas Administrative Code § 134.600 states, "(p) Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program."

The requestor seeks reimbursement for CPT codes 90801 and 96101 rendered on May 23, 2012. The insurance carrier denied the disputed charges with denial/reduction codes "216 – Based on the findings of a review organization."

Review of the preauthorization letter issued by Broadspire, dated May 22, 2012 documents that preauthorization was obtained for psychiatric diagnostic interview, 1 hour ad psychological testing, and 2 hours to include MMPI-2-RF, as an outpatient for depressive disorder related to chronic pain. The determination letter recommended pre-authorization effective on 5/18/2012-7/02/2012. Therefore, CPT codes 90801 and 96101 rendered on May 23, 2012 were preauthorized and are subject to review pursuant to 28 Texas Administrative Code § 134.203 (b).

3. 28 Texas Administrative Code §134.203 states, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

CPT code 90801 is defined as follows "Psychiatric diagnostic interview examination". The requestor submitted insufficient documentation to support 2 units of CPT code 90801, as a result, reimbursement will be considered for one unit per documentation submitted for review.

CPT code 96101 is defined as follows "Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report." Review of the documentation submitted by the requestor supports the 4 units billed for CPT code 96101, as a result, reimbursement will be considered for 4 units of CPT code 96101.

The MDR section completed NCCI edits for date of service May 23, 2012, to identify edit conflicts that would affect reimbursement. No NCCI edit conflicts were identified, as a result, CPT codes 90801 and 96101 rendered on May 23, 2012 will be reviewed pursuant to 28 Texas Administrative Code § 134.203 (c).

4. 28 Texas Administrative Code § 134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

28 Texas Administrative Code § 134.203 states, "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

The MAR reimbursement for CPT code 90801 rendered on May 23, 2012 is \$242.90, this amount is recommended.

The MAR reimbursement for CPT code 96101 rendered on May 23, 2012 is \$521.82, the requestor seeks reimbursement in the amount of \$507.84, and therefore, this amount is recommended.

Review of the submitted documentation finds that the requestor is entitled to additional reimbursement in the amount of \$750.74.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$750.74.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$750.74 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 14, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.